

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **02455**

2470

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			c. LENGTH OF STAY IN 1b 30 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BROWNSVILLE MD.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL				d. STREET ADDRESS BROWNSVILLE MD.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GARLAND CLIFFORD BACKUS				4. DATE OF DEATH Month Day Year FEBRUARY 26 1958 19			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 12 1882	
9. AGE (In years last birthday) 75 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRAFTSMAN		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CHARLESTOWN W. VA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME GEORGE C. BACKUS		14. MOTHER'S MAIDEN NAME LILLIAN LANGDON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address MRS. ELLEN B. BACKUS BROWNSVILLE MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 37 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary infarction						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/20, 1958 , to 7/26, 1958 , that I last saw the deceased alive on 7/26, 1958 , and that death occurred at 3:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John H. Hornbaker		ADDRESS (Street, city or town, state) 154 West Washington St., Hagerstown, Md.				DATE SIGNED 2:28:58	
PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MARCH 1 1958		22c. NAME OF CEMETERY OR CREMATORY ST. LUKES CEMETERY		22d. LOCATION (City, town, or county) (State) BROWNSVILLE WASH. CO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Barb Funeral Home Brownsboro Md.				24a. REC'D BY REGISTRAR MAR 5 58		24b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE

NAME OF DECEASED

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

PERMANENT CAUSE

DATE OF EXAMINATION

PLACE OF EXAMINATION

NAME OF PHYSICIAN

NAME OF SURGEON

NAME OF PATHOLOGIST

NAME OF ANATOMIST

NAME OF ASSISTANT

NAME OF NURSE

NAME OF ATTENDING PHYSICIAN

BUREAU V. 3

MAR 5 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2471

CERTIFICATE OF DEATH

Reg. Dist. No. 02456

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>5 weeks</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>														
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>40 Pin Oak Terrace</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print) <u>ROLAND</u>		First <u>ROLAND</u> Middle <u>C.</u> Last <u>BARNFATHER</u>		4. DATE OF DEATH Month <u>February</u> Day <u>9</u> Year <u>1958</u>														
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 12, 1902</u>		9. AGE (In years last birthday) <u>55</u> yrs. <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td><u>7</u></td> <td><u>27</u></td> <td></td> <td></td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	<u>7</u>	<u>27</u>		
IF UNDER 1 YEAR		IF UNDER 24 HRS.																
Months	Days	Hours	Min.															
<u>7</u>	<u>27</u>																	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Professor of Languages</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Junior College</u>		11. BIRTHPLACE (State or foreign country) <u>Pittsfield, Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>												
13. FATHER'S NAME <u>Irving J. Barnfather</u>				14. MOTHER'S MAIDEN NAME <u>Helen H. Holderness</u>														
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>W. W. II</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Jeanette Barnfather Hagerstown, Maryland</u>														
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Hepatitis</u> <u>581.0</u> DUE TO <u>Chronic Cirrhosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)												
21. I certify that I attended the deceased from <u>Jan 10, 1958</u> , to <u>Feb 9, 1958</u> , that I last saw the deceased alive on <u>Feb 9, 1958</u> , and that death occurred at <u>11:17 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Hagerstown, Md.</u> DATE SIGNED <u>Feb 9/58</u> ACTUAL SIGNATURE <u>J. H. Beackley</u> M.D. PHYSICIAN'S NAME (Type) <u>J. H. Beackley</u>																		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/13/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gardener Earl Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Troy, New York</u>												
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Rogers</u>				ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 13 '58</u>												
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>																		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 12-1-22		5. PLACE OF BIRTH MOBILE, ALA.	
6. OCCUPATION None		7. MARITAL STATUS Single		8. COLOR OF SKIN White		9. COLOR OF HAIR Brown		10. COLOR OF EYES Blue	
11. CAUSE OF DEATH Suicide		12. MANNER OF DEATH Homicide		13. PLACE OF DEATH Baltimore, Md.		14. DATE OF DEATH 4-4-68		15. TIME OF DEATH 10:00 AM	
16. SIGNATURE OF DECEASED None		17. SIGNATURE OF NEXT OF KIN None		18. SIGNATURE OF PHYSICIAN None		19. SIGNATURE OF CORONER None		20. SIGNATURE OF JURY None	
21. SIGNATURE OF REGISTRAR None		22. SIGNATURE OF CLERK None		23. SIGNATURE OF CHIEF OF POLICE None		24. SIGNATURE OF DISTRICT ATTORNEY None		25. SIGNATURE OF JUDGE None	

BUREAU V. S.

FEB 13 1968

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2472

CERTIFICATE OF DEATH

Reg. Dist. No.

02457
302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN TB 7 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
f. STREET ADDRESS 1821 Homewood Road				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ROBERT First MC KEAGE Middle BARR, SR. Last				4. DATE OF DEATH February Month 6 Day 1958 Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 10, 1892	
9. AGE (In years lost birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 8 Days 26		11. IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Mechanic				10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Hollidaysburg, Penna.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Ira C. Barr				14. MOTHER'S MAIDEN NAME Jane Bracken Mc Keage			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. 162-12-7522		17. INFORMANT Address Mrs. Daisey Barr Hagerstown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor Pulmonale + Congestive Failure 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Emphysema + Fibrosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 						INTERVAL BETWEEN ONSET AND DEATH 10 hours 4 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-22 , 19 58 , to 2-6 , 19 58 , that I last saw the deceased alive on 2:00 A.M. FEB. 6, 1958 , and that death occurred at 7:35 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 							
ACTUAL SIGNATURE J. D. Tanco M.D.							
PHYSICIAN'S NAME (Type) 							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/8/1958		22c. NAME OF CEMETERY OR CREMATORY Edge Hill Cemetery		22d. LOCATION (City, town, or county) (State) Charlestown, W. Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Super-Rouzer Funeral Home R. Franklin Meyer				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE FEB 10 1958	
				24b. REGISTRAR'S SIGNATURE W. J. Leach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		M		45		JAN 10, 1890		BALTIMORE		MD		USA			
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
Carpenter		Heart Disease		Natural		JAN 15, 1935		BALTIMORE		MD		USA			
FAMILY HISTORY		PREVIOUS ILLNESS		TREATMENT		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
None		None		None		JAN 15, 1935		BALTIMORE		MD		USA			
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY	
JAN 15, 1935		BALTIMORE		MD		USA				JAN 15, 1935		BALTIMORE		MD	
FAMILY HISTORY		PREVIOUS ILLNESS		TREATMENT		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
None		None		None		JAN 15, 1935		BALTIMORE		MD		USA			
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY	
JAN 15, 1935		BALTIMORE		MD		USA				JAN 15, 1935		BALTIMORE		MD	

BUREAU V. S.

FEB 10 1935

RECEIVED

25-9 CERTIFICATE OF DEATH

Reg. Dist. No. 02458

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Downsville Md.</u>				c. LENGTH OF STAY IN 1b <u>73 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Alfred</u> Middle <u>Earl</u> Last <u>Betts</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>18</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 1 1884</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u>10</u> Days <u>16</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Handyman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Downsville Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert E. Betts</u>				14. MOTHER'S MAIDEN NAME <u>Lavinia Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Claude Cline Downsville Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Downsville Md.</u>		(County) (State)	
21. I certify that I attended the deceased from <u>2/18/58</u> to <u>2/18/58</u> , that I last saw the deceased alive on <u>2/18/58</u> , and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Rogge F. Young</u>		M.D. <u>Williamsport Md</u>		DATE SIGNED <u>2/18/58</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb. 22-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		22d. LOCATION (City, town, or county) <u>Williamsport Maryland</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Young Williamsport Md</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 25 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Search</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 1

25 FEB 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2473

CERTIFICATE OF DEATH

Reg. Dist. No.

02459

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport Md RFD #2</u>	
		d. STREET ADDRESS <u>1</u>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Boppe</u> Last <u>Boppe</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>25</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 12 1886</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>5</u> Days <u>12</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Andrew Boppe</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Davis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>World War I</u>		16. SOCIAL SECURITY NO. <u>220 09 9012</u>	
17. INFORMANT <u>Mr. Charles E. Boppe</u>		Address <u>Waynesboro Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Thrombosis</u> DUE TO (c) <u>Heart</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/24/58</u> , 19 <u>58</u> , to <u>2/25/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2/25/58</u> , 19 <u>58</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ralph F. Young</u>		DATE SIGNED <u>2/25/58</u>	
PHYSICIAN'S NAME (Type) <u>RALPH F. YOUNG</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 28-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Williamsport Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Lutz</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 28 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>			

CERTIFICATE OF DEATH

1. PLACE OF DEATH		2. DATE OF DEATH	
3. NAME OF DECEASED		4. SEX	
5. AGE		6. RACE	
7. OCCUPATION		8. MARITAL STATUS	
9. CAUSE OF DEATH		10. MANNER OF DEATH	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESSES		14. SIGNATURE OF DECEASED	
15. SIGNATURE OF FUNERAL HOME		16. SIGNATURE OF BURIAL PLACE	
17. SIGNATURE OF CEMETERY		18. SIGNATURE OF INTERVIEWER	
19. SIGNATURE OF INTERVIEWER		20. SIGNATURE OF INTERVIEWER	
21. SIGNATURE OF INTERVIEWER		22. SIGNATURE OF INTERVIEWER	
23. SIGNATURE OF INTERVIEWER		24. SIGNATURE OF INTERVIEWER	
25. SIGNATURE OF INTERVIEWER		26. SIGNATURE OF INTERVIEWER	
27. SIGNATURE OF INTERVIEWER		28. SIGNATURE OF INTERVIEWER	
29. SIGNATURE OF INTERVIEWER		30. SIGNATURE OF INTERVIEWER	
31. SIGNATURE OF INTERVIEWER		32. SIGNATURE OF INTERVIEWER	
33. SIGNATURE OF INTERVIEWER		34. SIGNATURE OF INTERVIEWER	
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43. SIGNATURE OF INTERVIEWER		44. SIGNATURE OF INTERVIEWER	
45. SIGNATURE OF INTERVIEWER		46. SIGNATURE OF INTERVIEWER	
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49. SIGNATURE OF INTERVIEWER		50. SIGNATURE OF INTERVIEWER	
51. SIGNATURE OF INTERVIEWER		52. SIGNATURE OF INTERVIEWER	
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59. SIGNATURE OF INTERVIEWER		60. SIGNATURE OF INTERVIEWER	
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81. SIGNATURE OF INTERVIEWER		82. SIGNATURE OF INTERVIEWER	
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89. SIGNATURE OF INTERVIEWER		90. SIGNATURE OF INTERVIEWER	
91. SIGNATURE OF INTERVIEWER		92. SIGNATURE OF INTERVIEWER	
93. SIGNATURE OF INTERVIEWER		94. SIGNATURE OF INTERVIEWER	
95. SIGNATURE OF INTERVIEWER		96. SIGNATURE OF INTERVIEWER	
97. SIGNATURE OF INTERVIEWER		98. SIGNATURE OF INTERVIEWER	
99. SIGNATURE OF INTERVIEWER		100. SIGNATURE OF INTERVIEWER	

BUREAU V. B.

FEB 28 1958

RECEIVED

2474

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>624 JALEM AVE</u>		d. STREET ADDRESS <u>1 624 JALEM AVE</u>	
3. NAME OF DECEASED (Type or print) First <u>EFFIE</u> Middle <u>CLARA</u> Last <u>BOYCE</u>		4. DATE OF DEATH Month <u>FEB</u> Day <u>24</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 5, 1869</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>SEVEN MOUNTAINS, VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JILAS MUNCH</u>		14. MOTHER'S MAIDEN NAME <u>REBECCA BARR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Joseph E. Clem</u>		Address <u>624 JALEM AVE. HAGERSTOWN, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Myocardial Infarction</u> (c) INTERVAL BETWEEN ONSET AND DEATH <u>6 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-1-57</u> , to <u>2-24-58</u> , that I last saw the deceased alive on <u>2-21-58</u> , 19 <u>58</u> , and that death occurred at <u>5 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>Hagerstown, MD.</u>	
PHYSICIAN'S NAME (Type) <u>[Signature]</u>		DATE SIGNED <u>2/24/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-27-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Detrick Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Detrick, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel</u>		24a. RECEIVED BY REGISTRAR <u>[Signature]</u>	
ADDRESS <u>Hagerstown, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2475

CERTIFICATE OF DEATH

Reg. Dist. No.

02461

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Maryland				c. LENGTH OF STAY IN 1b 2 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 406 N. Jonathan Street.				d. STREET ADDRESS 406 N. Jonathan Street.			
3. NAME OF DECEASED (Type or print) First Martha Middle Annadethia Last Brooks				4. DATE OF DEATH Month 2 Day 5 Year 1958			
5. SEX Female		6. COLOR OR RACE Celored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 13 1881	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Beaver Creek Md.	
12. CITIZEN OF WHAT COUNTRY? USA.							
13. FATHER'S NAME Michael Tayler				14. MOTHER'S MAIDEN NAME Rebecca James			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Leila Branch 406 N. Jonathan St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extensive Coronary artery disease 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 13 1957 to Feb 5 1958 , that I last saw the deceased alive on Feb 5 1958 , and that death occurred at 8 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 159 W. Washington St. Hagerstown Md. DATE SIGNED Feb 11 1958							
ACTUAL SIGNATURE Philip J. Hirshman				PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D. 159 W. Washington St., Hagerstown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-9-1958		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Watson Jr. Hagerstown Md.				24a. REC'D BY REGISTRAR DATE FEB 11 1958		24b. REGISTRAR'S SIGNATURE Alfred Lewis	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

John V. ...

RECEIVED

FEB 11 1938

BUREAU V. E.

Form with multiple sections and fields, mostly illegible due to blurriness. Visible text includes "BUREAU V. E." and "FEB 11 1938".

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2476

CERTIFICATE OF DEATH

Reg. Dist. No.

02462

1. PLACE OF DEATH a. COUNTY WASHINGTON		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 1		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TREGO		d. STREET ADDRESS TREGO WASH. CO. MD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last KAREN SUE BUCK		4. DATE OF DEATH Month Day Year FEBRUARY 8 1958 19		5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEBRUARY 8 1958		9. AGE (In years lost birthday) yrs. Months Days Hours Min. 34	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) HAGERSTOWN WASH. CO. MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME PRESTON BUCK		14. MOTHER'S MAIDEN NAME DOROTHY PEPPLER		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT PRESTON BUCK TREGO MD.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Eclampsia Cordis with 754.5 DUE TO persistent transient asystole Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Morgellon (c) Morgellon		INTERVAL BETWEEN ONSET AND DEATH 1/2 hr		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from FEB 8 , 1958, to FEB 8 , 1958, that I last saw the deceased alive on FEB 8 , 1958, and that death occurred at 11 A.M. , from the causes and on the date stated above.													
ACTUAL SIGNATURE L. L. Packer		ADDRESS (Street, city or town, state) 145 W. Washington St		DATE SIGNED 2/10/58		PHYSICIAN'S NAME (Type) L. L. Packer, M.D.		Hagerstown, Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF FEB 9 1958		22c. NAME OF CEMETERY OR CREMATORY ROHRERSVILLE CEMETERY		22d. LOCATION (City, town, or county) (State) ROHRERSVILLE MARYLAND		24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE 2081313xv4			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dr. Packer 145 W. Wash. St. Hagerstown 8455 Summit Ave.

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
HUSBAND		MOTHER	
FATHER		SISTER	
BROTHER		CHILD	
GRANDFATHER		GRANDMOTHER	
AUNT		UNCLE	
Nephew		Niece	
Cousin		Sister-in-law	
Brother-in-law		Friend	
Neighbor		Other	
Cause of Death		Place of Burial	
Time of Death		Age at Death	
Sex		Race	
Color		Religion	
Marital Status		Occupation	
Education		Previous Illness	
Medical History		Mental History	
Social History		Family History	
Personal History		Other History	

BUREAU V. 21

FEB 13 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02463

Reg. Dist. No.

2477

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
c. LENGTH OF STAY IN life		d. STREET ADDRESS 1845 Penna Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1845 Penna Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Ellsworth Byers		4. DATE OF DEATH Month Feb. Day 12 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 21, 1897
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) W. M. R. R.		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Washington Co. Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John H. Byers		14. MOTHER'S MAIDEN NAME Minnie Mayhugh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705-12-2026	
17. INFORMANT Mrs. Mary Byers - 1845 Penna Ave-Hagerstown, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) (County) (State) - - -	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE S. Robert Wells		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-15-58	
22c. NAME OF CEMETERY OR CREMATORY Beautiful View		22d. LOCATION (City, town, or county) (State) Washington County, Md	
23. FUNERAL DIRECTOR'S SIGNATURE A.E. Winnick - Greencastle, Pa.		24a. REC'D BY REGISTRAR DATE FEB 19 58	
		24b. REGISTRAR'S SIGNATURE A.E. Winnick	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by you or your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT

RECEIVED
FEB 19 1958
BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2510 CERTIFICATE OF DEATH

02464

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN RURAL</u>				c. LENGTH OF STAY IN 1b <u>27 YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ECKSTINE ROAD</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>FLORENCE</u> First <u>S</u> Middle <u>CLARK</u> Last				4. DATE OF DEATH <u>FEBRUARY-6-</u> 19 <u>58</u> Month Day Year			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 31-1874</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>SHEPHERDSTOWN W. VA. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JAMES DOFFENBERGER</u>				14. MOTHER'S MAIDEN NAME <u>MARY DUSING</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>WILLIAM F. CLARK</u> Address <u>HAGERSTOWN MD. B.3</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>DUE TO</u> (c) <u>DUE TO</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Cardiovascular Disease.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan. 20, 1958</u> to <u>Feb. 6, 1958</u> , that I last saw the deceased alive on <u>Feb. 6, 1958</u> , and that death occurred at <u>11:35 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R.A. Bell</u>				ADDRESS (Street, city or town, state) <u>119 North Potomac St. 2-8-58</u>			
PHYSICIAN'S NAME (Type) <u>R.A. Bell, M.D.</u>				DATE SIGNED <u>Hagerstown, Maryland.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>FEB. 9. 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BEST HAVEN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>HAGERSTOWN WASH. Co. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Best Funeral Home</u>				ADDRESS <u>BOONSBORO MD.</u>		24a. RECEIVED BY REGISTRAR <u>DATE</u>	
24b. REGISTRAR'S SIGNATURE							

RECEIVED

FEB 10 1958

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

EDUCATION

OCCUPATION

RELIGION

ETHNIC ORIGIN

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF ARRIVAL

PLACE OF ARRIVAL

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DATE OF DEPARTURE

PLACE OF DEPARTURE

02465

2511 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOONSBORO		c. LENGTH OF STAY IN 1b 39 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOONSBORO	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ST. PAUL ST.		/d. STREET ADDRESS ST. PAUL ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle S Last GLOPPER		4. DATE OF DEATH Month FEBRUARY Day 13 Year 1958		19	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 10 1895	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY HARDWARE STORE		11. BIRTHPLACE (State or foreign country) KEEDYSVILLE WASH. CO. MD. U.S.A.	
13. FATHER'S NAME FRANK CLOPPER		14. MOTHER'S MAIDEN NAME NANCY FRYE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214 09 2426		17. INFORMANT MRS. RUTH CLOPPER BOONSBORO MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Boonsboro	
20f. (City or town) Boonsboro		(County) Washington		(State) Md.	
21. I certify that I attended the deceased from Jan 15 , 19 58 , to February 13 , 19 58 , that I last saw the deceased alive on February 7 , 19 58 , and that death occurred at 9:30 A . M, from the causes and on the date stated above		ADDRESS (Street, city or town, state) Boonsboro		DATE SIGNED 2-14-58	
ACTUAL SIGNATURE G. W. Hevan		M.D. Ind			
PHYSICIAN'S NAME (Type) G. W. Hevan					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF FEB. 16 1958		22c. NAME OF CEMETERY OR CREMATORY BOONSBORO CEMETERY BOONSBORO WASH. CO. MD.	
22d. LOCATION (City, town, or county) Boonsboro Md.		(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE East Funeral Home		ADDRESS Boonsboro Md.		24a. REC'D BY REGISTRAR FEB 19 58	
				24b. REGISTRAR'S SIGNATURE W. Hevan	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

File (Date)

BUREAU V. 5

FEB 19 1958

RECEIVED

2478

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.				c. LENGTH OF STAY IN 1b 41 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. STREET ADDRESS 438 N. Jonathan Street			
3. NAME OF DECEASED (Type or print) First Jessie Middle May Last Coffee				4. DATE OF DEATH Month Feb Day 28 Year 1958			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 12 1889	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Camden S.C.	
12. CITIZEN OF WHAT COUNTRY? USA.							
13. FATHER'S NAME John Collin				14. MOTHER'S MAIDEN NAME Unknew			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Adolphus Coffee 438 N. Jonathan Street			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetes M DUE TO Peripheral vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute cerebral thrombosis DUE TO Acute Pulmonary emboli (c) Phelibitis of Femoral vein-lt							INTERVAL BETWEEN ONSET AND DEATH 10 yrs 15 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year Hour o. m. none 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input checked="" type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 1948 to Feb. 28 1958 , that I last saw the deceased alive on Feb. 28 1958 , and that death occurred at 9:30A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE S. Robert Wells M.D.				ADDRESS (Street, city or town, state) 115 N. Potomac Street DATE SIGNED 3-2-58			
PHYSICIAN'S NAME (Type) S. Robert Wells, M.D.				Hagerstown Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-3-1958		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John R Watson Jr. Hagerstown Md. ADDRESS				24a. REC'D BY REGISTRAR DATE MAR 6 '58		24b. REGISTRAR'S SIGNATURE Alfred Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3. *Ch. m. m.*

BUREAU V. S.

1958 6 MAR

RECEIVED

James A. Thompson, Jr. - 1895

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02467

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg		c. LENGTH OF STAY IN 1b 20 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg	
		f. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First George Middle Henry Last Dean		4. DATE OF DEATH Month Feb. Day 10 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 24 1886
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chiropractor		10b. KIND OF BUSINESS OR INDUSTRY self employed	
11. BIRTHPLACE (State or foreign country) near Toronto, Ont. Canada		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Dean		14. MOTHER'S MAIDEN NAME Ellen Raye	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 169-09-3824	
17. INFORMANT Mrs. Blanche Holmes Dean, Smithsburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) - - -	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 2/12/58	
22c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		22d. LOCATION (City, town, or county) (State) Smithsburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Katherine Hove		24a. REC'D BY REGISTRAR Waynesboro Pa.	
		24b. REGISTRAR'S SIGNATURE Feb 14 '58	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by you or your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH BOARD



BUREAU V. S.

FEB 14 1953

RECEIVED

2479

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md.</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Dwayne</u> Last <u>Dehler</u>		4. DATE OF DEATH Month <u>February</u> Day <u>21</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February-19-58</u>
9. AGE (In years last birthday) yrs. <u>2</u>		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min. <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Gordon Dehler</u>		14. MOTHER'S MAIDEN NAME <u>Jean Suttie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Gordon Dehler</u>		Address <u>1314 Potomac ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>762.5</u> IMMEDIATE CAUSE (a) <u>Manual atelectasis</u> DUE TO <u>Prematurely 2 hrs 50</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>2 days</u> (c) <u>6 hours?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hours?</u> <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/19/58</u> to <u>2/21/58</u> , that I last saw the deceased alive on <u>2/21/58</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. M. Becorje</u>		DATE SIGNED <u>302 N. Potomac Ave St 2/22/58</u>	
PHYSICIAN'S NAME (Type) <u>Hagerstown Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-22-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A.K. Coffman</u>		ADDRESS <u>40E. Antietam St.</u>	
24a. REC'D BY REGISTRAR <u>FEB 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	

2081262XVI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

FEB 24 1938

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2480

CERTIFICATE OF DEATH

Reg. Dist. No. 02469

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md.</u>				c. LENGTH OF STAY IN 1b <u>30 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Cleveland</u> Last <u>De Louney</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>25</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 11 1886</u>		9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>13</u> Hours <u>13</u> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret'd Railroad Man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Western Md. R. R.</u>		11. BIRTHPLACE (State or foreign country) <u>Sharpsburg Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Charles De Louney</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ellen James</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>705 10 4737</u>		17. INFORMANT <u>Mr. Richard De Louney</u> Address <u>64 Winter St. Hagerstown Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive pulmonary embolism, right pulmonary artery</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (a) <u>Early bronchial pneumonia, right upper and middle lobes.</u> (b) <u>Hypertensive cardiovascular disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>(c) Cerebral arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24-36 hrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>p. m.</u>	Month, <u>19</u>	Day, <u>19</u>	Year, <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Hagerstown</u>	(County) <u>Washington</u> (State) <u>Md.</u>
21. I certify that I attended the deceased from <u>February 24 1958</u> to <u>February 25 1958</u> , that I last saw the deceased alive on <u>February 25 1958</u> , and that death occurred at <u>9:00 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>M.D. 100 Professional Arts Bldg.</u> DATE SIGNED <u>2/28/58</u>							
ACTUAL SIGNATURE <u>William T. Layman, M.D.</u>				PHYSICIAN'S NAME (Type) <u>William T. Layman</u> <u>Hagerstown, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 1-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Sharpsburg Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf Wilkerson, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 3 58</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Leach</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. OCCUPATION		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF CORONER	
16. SIGNATURE OF JUDGE		17. SIGNATURE OF CLERK		18. SIGNATURE OF SHERIFF	
19. SIGNATURE OF DEPUTY SHERIFF		20. SIGNATURE OF CONSTABLE		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
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73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
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91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

BUREAU V. 3

JAN 3 1958

RECEIVED

2513

CERTIFICATE OF DEATH

02470

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Smithsburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Smithsburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RD # 2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALICE Middle SUSAN Last DETROW		4. DATE OF DEATH Month Feb. Day 9 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 11, 1876
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Ringgold, Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John S.B. Sigler	
14. MOTHER'S MAIDEN NAME Susan Sites		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. ---		17. INFORMANT Address Mrs. Clarence Duffey, RD # 2, Smithsburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) 5 yrs.			INTERVAL BETWEEN ONSET AND DEATH 7 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12-14-56 , 19____, to 2-9-58 , 19____, that I last saw the deceased alive on 2-9-58 , 19____, and that death occurred at 2:00P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles F. Hess		ADDRESS (Street, city or town, state) Smithsburg, Maryland	
DATE SIGNED 2-10-58			
PHYSICIAN'S NAME (Type) Charles F. Hess, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 12, 1958	22c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery	22d. LOCATION (City, town, or county) (State) Waynesboro, Penna.
23. FUNERAL DIRECTOR'S SIGNATURE S. Martin Poe		ADDRESS Waynesboro, Penna.	
24a. REC'D BY REGISTRAR DATE FEB 13 '58		24b. REGISTRAR'S SIGNATURE W. H. Leach	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 10

FEB 13 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2481

CERTIFICATE OF DEATH

02471

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNION BRIDGE 06X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WESTERN MARYLAND STATE HOSPITAL				d. STREET ADDRESS 2 E. ELGER ST.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last BLANCHE MARIE FOGLE				4. DATE OF DEATH Month Day Year FEB. 27 1958			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/24/23	
9. AGE (In years last birthday) 34 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) SUMMERSSET, PENNA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JOHN GORDON BRANT				14. MOTHER'S MAIDEN NAME ELSIE FLORENCE EMMERT,			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address GERALD E. FOGLE 2 E. ELGER ST. UNION BRIDGE MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASTROCYTOMA RT. FRONTAL LOBE 193.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 1 YEAR
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from FEB. 14 , 19 58 , to FEB. 27 , 19 58 , that I last saw the deceased alive on FEB. 27 , 19 58 , and that death occurred at 10.45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) WESTERN MARYLAND STATE HOSPITAL DATE SIGNED MD.							
ACTUAL SIGNATURE George Beran, M.D.							
PHYSICIAN'S NAME (Type) DR. GEORGE BERAN				HAGERSTOWN, MARYLAND.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/2/58		22c. NAME OF CEMETERY OR CREMATORY Linganore Cemetery		22d. LOCATION (City, town, or county) (State) MD.	
23. FUNERAL DIRECTOR'S SIGNATURE D. D. Hartzler ADDRESS Union Bridge MD.				24a. REC'D BY REGISTRAR DATE FEB 28 '58		24b. REGISTRAR'S SIGNATURE W. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF BIRTH	
10. DATE OF BIRTH		11. SEX OF BIRTH		12. AGE AT BIRTH	
13. DATE OF DEATH		14. TIME OF DEATH		15. PLACE OF DEATH	
16. CAUSE OF DEATH		17. MANNER OF DEATH		18. PLACE OF BIRTH	
19. DATE OF BIRTH		20. SEX OF BIRTH		21. AGE AT BIRTH	
22. DATE OF DEATH		23. TIME OF DEATH		24. PLACE OF DEATH	
25. CAUSE OF DEATH		26. MANNER OF DEATH		27. PLACE OF BIRTH	
28. DATE OF BIRTH		29. SEX OF BIRTH		30. AGE AT BIRTH	
31. DATE OF DEATH		32. TIME OF DEATH		33. PLACE OF DEATH	
34. CAUSE OF DEATH		35. MANNER OF DEATH		36. PLACE OF BIRTH	
37. DATE OF BIRTH		38. SEX OF BIRTH		39. AGE AT BIRTH	
40. DATE OF DEATH		41. TIME OF DEATH		42. PLACE OF DEATH	
43. CAUSE OF DEATH		44. MANNER OF DEATH		45. PLACE OF BIRTH	
46. DATE OF BIRTH		47. SEX OF BIRTH		48. AGE AT BIRTH	
49. DATE OF DEATH		50. TIME OF DEATH		51. PLACE OF DEATH	
52. CAUSE OF DEATH		53. MANNER OF DEATH		54. PLACE OF BIRTH	
55. DATE OF BIRTH		56. SEX OF BIRTH		57. AGE AT BIRTH	
58. DATE OF DEATH		59. TIME OF DEATH		60. PLACE OF DEATH	
61. CAUSE OF DEATH		62. MANNER OF DEATH		63. PLACE OF BIRTH	
64. DATE OF BIRTH		65. SEX OF BIRTH		66. AGE AT BIRTH	
67. DATE OF DEATH		68. TIME OF DEATH		69. PLACE OF DEATH	
70. CAUSE OF DEATH		71. MANNER OF DEATH		72. PLACE OF BIRTH	
73. DATE OF BIRTH		74. SEX OF BIRTH		75. AGE AT BIRTH	
76. DATE OF DEATH		77. TIME OF DEATH		78. PLACE OF DEATH	
79. CAUSE OF DEATH		80. MANNER OF DEATH		81. PLACE OF BIRTH	
82. DATE OF BIRTH		83. SEX OF BIRTH		84. AGE AT BIRTH	
85. DATE OF DEATH		86. TIME OF DEATH		87. PLACE OF DEATH	
88. CAUSE OF DEATH		89. MANNER OF DEATH		90. PLACE OF BIRTH	
91. DATE OF BIRTH		92. SEX OF BIRTH		93. AGE AT BIRTH	
94. DATE OF DEATH		95. TIME OF DEATH		96. PLACE OF DEATH	
97. CAUSE OF DEATH		98. MANNER OF DEATH		99. PLACE OF BIRTH	
100. DATE OF BIRTH		101. SEX OF BIRTH		102. AGE AT BIRTH	

BUREAU V. 3

FEB 28 1958

RECEIVED

FILED IN BUREAU

2482

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penna		b. COUNTY Fayette	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 5 Mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hopwood		75 X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 424 Edgewood Drive				d. STREET ADDRESS R D # 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HELEN Middle TAYLOR Last FRIEND				4. DATE OF DEATH Month February Day 17 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 26 1884		9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Braceville Ill		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ralph Yeardley				14. MOTHER'S MAIDEN NAME Catherine Taylor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs Robt P. Grove 424 Edgewood Drive Hagerstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive C.V. Disease (c) C Lys. Hemiplegia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 7-12-1958							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jul 13 , 1958, to Feb. 17 , 1958, that I last saw the deceased alive on Feb. 17 , 1958, and that death occurred at 3 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Sidney Novenstein M.D.				ADDRESS (Street, city or town, state) Fayette		DATE SIGNED 2-17-58	
PHYSICIAN'S NAME (Type) SIDNEY NOVENSTEIN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/20/58		22c. NAME OF CEMETERY OR CREMATORY Friend Cemetery near		22d. LOCATION (City, town, or county) (State) Swanton Garrett Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown Md.		24a. RECEIVED BY REGISTRAR Feb 20 1958	
				24b. REGISTRAR'S SIGNATURE W. Keach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
CERTIFICATE OF DEATH

WILLIAM BOND

BUREAU V. 3

FEB 20 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2514

CERTIFICATE OF DEATH

02473

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport				c. LENGTH OF STAY IN 1b 8 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Williamsport Sanitarium				d. STREET ADDRESS 122 North Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DAISY First Middle Last GAVER				4. DATE OF DEATH Month Feb. Day 26 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 21, 1876	
9. AGE (In years lost birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Newton, Indiana				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Graff				14. MOTHER'S MAIDEN NAME Elmira Slifer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Rex Gaver Address 122 North Ave. Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease with 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) myocardial failure DUE TO (c) Urinary Tract infection						INTERVAL BETWEEN ONSET AND DEATH 5 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Urinary Tract infection						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from apr 19 58 to 26 Feb 19 58 , that I last saw the deceased alive on 25 Feb 19 58 , and that death occurred at 12 30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE F. F. Lusby		M.D. 2301 Potomac St		ADDRESS (Street, city or town, state) Hagerstown		DATE SIGNED 26 Feb 58	
PHYSICIAN'S NAME (Type) F. F. Lusby							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/28/58		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc.				ADDRESS 1601 Penna. Ave. Hagerstown, Md.		24a. REC'D BY REGISTRAR MAR 3 '58	
				24b. REGISTRAR'S SIGNATURE W. H. Beach			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

MAR 3 1958

RECEIVED

2483

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 51 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS 521 Jefferson St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Charles Ellis Hartle				4. DATE OF DEATH Month Day Year February 17 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 20, 1906		9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Hagerstown Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Hartle				14. MOTHER'S MAIDEN NAME Sarah Bowers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. W. W. 11 214-09-6104		17. INFORMANT Address Mrs. Dorothy Poffenberger Hag. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of esophagus 150x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of esophagus DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 4 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malnutrition						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1/16/58 to 17 Feb , 19 58 , that I last saw the deceased alive on 17 Feb , 19 58 , and that death occurred at 11:35p , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 115 W. Washington St Hag Md. DATE SIGNED _____							
ACTUAL SIGNATURE Eldon G. Hoachlander				PHYSICIAN'S NAME (Type) Eldon G. Hoachlander			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-20-58		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Scott F. Minnich & Son Hagerstown Md.				24a. REC'D BY REGISTRAR DATE FEB 21 1958		24b. REGISTRAR'S SIGNATURE Scott F. Minnich	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased William Harbo		Age 31 years		Sex Male		Race White		Marital Status Single		Date of Death March 20, 1908		Place of Death Baltimore, Md.		Cause of Death Tuberculosis	
Name of Informant Scott T. Minchin & Son		Address Baltimore, Md.		Relationship Son		Signature [Signature]		Date March 21, 1908		Place Baltimore, Md.		Signature [Signature]		Date March 21, 1908	

BUREAU V. S.

FEB 21 1908

RECEIVED

Scott T. Minchin & Son
Baltimore, Md.
March 21, 1908
[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2484

CERTIFICATE OF DEATH

02475

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. STREET ADDRESS <u>13 Fenton Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Lewis</u> Middle <u>Cleveland</u> Last <u>Hawbecker</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>20</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 9 1892</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>10</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mill Work Dye Room</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tannery</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Hawbecker</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Vandrew</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>World War I</u>		16. SOCIAL SECURITY NO. <u>215 01 9950</u>	
17. INFORMANT <u>Mrs. Lola S. Hawbecker</u>		Address <u>13 Fenton Ave. Williamsport Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular disease</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 19, 1958</u> , to <u>Feb 20, 1958</u> , that I last saw the deceased alive on <u>Feb 20, 1958</u> , and that death occurred at <u>12:40 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>JD Turco</u> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 23-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Williamsport Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Leaf Williamsport, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 25 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 2 Film Q226 3-7-58 et
2515
CERTIFICATE OF DEATH

02476

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frank Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence, before admission) o. STATE <u>md.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maugansville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Maugansville Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Maugansville Mennonite Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SEAL</u> <u>HEMLIN</u>		4. DATE OF DEATH Month Day Year <u>Feb.</u> <u>26</u> <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 19, 1875</u>
9. AGE (In years lost birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fence Builder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	
11. BIRTHPLACE (State or foreign country) <u>Lancaster Co., Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Hemlin</u>		14. MOTHER'S MAIDEN NAME <u>Sirenah ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Susan Hemlin</u>		Address <u>Maugansville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arterio-sclerotic heart disease</u> DUE TO (c) <u>10 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-1-57</u> , 19 <u>57</u> , to <u>2-26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2-24-58</u> , 19 <u>58</u> , and that death occurred at <u>1:00 p.m.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr. E. W. Dittus</u>		ADDRESS (Street, city, town, state) <u>Hagerstown, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Dr. E. W. Dittus</u>		DATE SIGNED <u>3/27/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B.</u>		22b. DATE THEREOF <u>3/1/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Paradise Church Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Wash. Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. E. Minnich</u>		ADDRESS <u>Greencastle, Pa.</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 3</u> <u>58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Redick</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2485

CERTIFICATE OF DEATH

02477

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Greencastle 75x-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hospital</u>		d. STREET ADDRESS <u>RD1 - Greencastle</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JACOB</u> First <u>Edwin</u> Middle <u>HORSH</u> Last		4. DATE OF DEATH <u>Feb. 22</u> Month <u>22</u> Day <u>1958</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/15/1888</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boer Bros. Labour</u>		11. BIRTHPLACE (State or foreign country) <u>Upton, Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Abraham Horsh</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Ellen Sheeley</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>214-09-9246</u>		17. INFORMANT <u>Michael Horsh</u> Address <u>Upton, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery atherosclerosis, thrombosis and myocardial infarction.</u> 420.1 <u>XXXX</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes mellitus</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 20 years 20 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19 <u>48</u> , to <u>2/22</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2/22</u> , 19 <u>58</u> , and that death occurred at <u>5:32 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.C. Brewer</u>		ADDRESS (Street, city or town, state) <u>359 E. Baltimore St., Greencastle, Pa.</u> DATE SIGNED <u>2/22/58</u>	
PHYSICIAN'S NAME (Type) <u>W. C. Brewer, M.D.</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/25/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A.E. Munnich</u> ADDRESS <u>Greencastle Pa.</u>		24a. REC'D BY REGISTRAR <u>Feb 25 '58</u> DATE 24b. REGISTRAR'S SIGNATURE <u>Overman</u>	

CERTIFICATE OF DEATH

1. PLACE OF DEATH A. HOME		2. PLACE OF DEATH B. HOSPITAL		3. PLACE OF DEATH C. OTHER	
4. NAME OF DECEASED		5. SEX		6. AGE	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. MANNER OF DEATH		11. PLACE OF BIRTH		12. DATE OF BIRTH	
13. OCCUPATION		14. EDUCATION		15. RELIGION	
16. MARITAL STATUS		17. PREVIOUS MARRIAGES		18. PREVIOUS DEATHS	
19. PRESENT RESIDENCE		20. PREVIOUS RESIDENCES		21. PREVIOUS DEATHS	
22. PRESENT ADDRESS		23. PREVIOUS ADDRESSES		24. PREVIOUS DEATHS	
25. PRESENT PHONE		26. PREVIOUS PHONES		27. PREVIOUS DEATHS	
28. PRESENT MAILING ADDRESS		29. PREVIOUS MAILING ADDRESSES		30. PREVIOUS DEATHS	
31. PRESENT SOCIAL SECURITY NUMBER		32. PREVIOUS SOCIAL SECURITY NUMBERS		33. PREVIOUS DEATHS	
34. PRESENT MEDICAL RECORD NUMBER		35. PREVIOUS MEDICAL RECORD NUMBERS		36. PREVIOUS DEATHS	
37. PRESENT HEALTH INSURANCE NUMBER		38. PREVIOUS HEALTH INSURANCE NUMBERS		39. PREVIOUS DEATHS	
40. PRESENT LIFE INSURANCE NUMBER		41. PREVIOUS LIFE INSURANCE NUMBERS		42. PREVIOUS DEATHS	
43. PRESENT AUTO INSURANCE NUMBER		44. PREVIOUS AUTO INSURANCE NUMBERS		45. PREVIOUS DEATHS	
46. PRESENT FIRE INSURANCE NUMBER		47. PREVIOUS FIRE INSURANCE NUMBERS		48. PREVIOUS DEATHS	
49. PRESENT LIFE SAVING NUMBER		50. PREVIOUS LIFE SAVING NUMBERS		51. PREVIOUS DEATHS	
52. PRESENT LIFE SAVING NUMBER		53. PREVIOUS LIFE SAVING NUMBERS		54. PREVIOUS DEATHS	
55. PRESENT LIFE SAVING NUMBER		56. PREVIOUS LIFE SAVING NUMBERS		57. PREVIOUS DEATHS	
58. PRESENT LIFE SAVING NUMBER		59. PREVIOUS LIFE SAVING NUMBERS		60. PREVIOUS DEATHS	
61. PRESENT LIFE SAVING NUMBER		62. PREVIOUS LIFE SAVING NUMBERS		63. PREVIOUS DEATHS	
64. PRESENT LIFE SAVING NUMBER		65. PREVIOUS LIFE SAVING NUMBERS		66. PREVIOUS DEATHS	
67. PRESENT LIFE SAVING NUMBER		68. PREVIOUS LIFE SAVING NUMBERS		69. PREVIOUS DEATHS	
70. PRESENT LIFE SAVING NUMBER		71. PREVIOUS LIFE SAVING NUMBERS		72. PREVIOUS DEATHS	
73. PRESENT LIFE SAVING NUMBER		74. PREVIOUS LIFE SAVING NUMBERS		75. PREVIOUS DEATHS	
76. PRESENT LIFE SAVING NUMBER		77. PREVIOUS LIFE SAVING NUMBERS		78. PREVIOUS DEATHS	
79. PRESENT LIFE SAVING NUMBER		80. PREVIOUS LIFE SAVING NUMBERS		81. PREVIOUS DEATHS	
82. PRESENT LIFE SAVING NUMBER		83. PREVIOUS LIFE SAVING NUMBERS		84. PREVIOUS DEATHS	
85. PRESENT LIFE SAVING NUMBER		86. PREVIOUS LIFE SAVING NUMBERS		87. PREVIOUS DEATHS	
88. PRESENT LIFE SAVING NUMBER		89. PREVIOUS LIFE SAVING NUMBERS		90. PREVIOUS DEATHS	
91. PRESENT LIFE SAVING NUMBER		92. PREVIOUS LIFE SAVING NUMBERS		93. PREVIOUS DEATHS	
94. PRESENT LIFE SAVING NUMBER		95. PREVIOUS LIFE SAVING NUMBERS		96. PREVIOUS DEATHS	
97. PRESENT LIFE SAVING NUMBER		98. PREVIOUS LIFE SAVING NUMBERS		99. PREVIOUS DEATHS	
100. PRESENT LIFE SAVING NUMBER		101. PREVIOUS LIFE SAVING NUMBERS		102. PREVIOUS DEATHS	

BUREAU V. H.

18 25 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2516

CERTIFICATE OF DEATH

02478

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cavetown		c. LENGTH OF STAY IN 1b 40 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 55		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Carrie Middle Mae Last Kendall		4. DATE OF DEATH Month February Day 24 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 13, 1878
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Smithsburg Md. Rt. 1		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Hezekiah Holtzman		14. MOTHER'S MAIDEN NAME Mary Fulton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 422.1	
17. INFORMANT George T. Kendall		Address Cavetown Box 55	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-12 , 19 54 , to 2-24 , 19 58 , that I last saw the deceased alive on 1-28 , 19 58 , and that death occurred at 7:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Charles F. Hess M.D. 2-25-58 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Charles F. Hess M.D. Smithsburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-27-58	
22c. NAME OF CEMETERY OR CREMATORY Welty Cemetery		22d. LOCATION (City, town, or county) (State) Greensburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Smithsburg Md.	
24a. REC'D BY REGISTRAR WAR 3 '58		24b. REGISTRAR'S SIGNATURE W. H. H. H.	

BUREAU V. 3.

MAR 3 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02479

2486

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Maryland</u> <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>16 yrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>		d. STREET ADDRESS <u>541 Ridge Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NINA</u> Middle <u>FLORENCE</u> Last <u>KEYTON</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>24</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 19, 1908</u>
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Harrisonburg, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henby Randolph</u>		14. MOTHER'S MAIDEN NAME <u>Dora Ellen Lokey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>225-18-6844</u>	
17. INFORMANT <u>John W. Keyton</u>		Address <u>541 Ridge Ave. Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>158 X Retroperitoneal Sarcoma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension - left kidney (acute)</u> DUE TO (c) <u>7 mo.</u> INTERVAL BETWEEN ONSET AND DEATH <u>7 mo.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 3, 1953</u> to <u>Feb 24, 1958</u> , that I last saw the deceased alive on <u>Feb 24, 1958</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Philip J. Hirshman</u>		M.D. <u>159 W. Washington St.</u>	
PHYSICIAN'S NAME (Type) <u>Philip J. Hirshman</u>		DATE SIGNED <u>2/26/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/27/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</u>		ADDRESS <u>1601 Penna. Ave.</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 3 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. ...</u>	

BUREAU V. S.

MAR 3 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2487

CERTIFICATE OF DEATH

02480

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland				c. LENGTH OF STAY IN 1b 35 yrs				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Maryland 03			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 112 W. North Street				d. STREET ADDRESS 112 W. North Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Agnes Middle Alice Last King				4. DATE OF DEATH Month Feb Day 17 Year 19 58							
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 25 1878		9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Shepherdstown, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Henry Dorsey				14. MOTHER'S MAIDEN NAME Nannie Hopewell							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) ne				16. SOCIAL SECURITY NO. nene		17. INFORMANT Mrs Iame Wilson 110 W. North, Street Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Pancreas 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 7 mo	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Aug 19 57 , to Feb 17 19 58 , that I last saw the deceased alive on Feb 17 19 58 , and that death occurred at 9 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 214 N. Potomac St. DATE SIGNED 2/18/58 ACTUAL SIGNATURE Lloyd A. Hoffman M.D. PHYSICIAN'S NAME (Type) Lloyd A. Hoffman Hagerstown, Md											
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Feb 21 1958		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Shepherdstown W. Va.					
23. FUNERAL DIRECTOR'S SIGNATURE John R Watson Jr Hagerstown Md ADDRESS						24a. REC'D BY REGISTRAR DATE FEB 20 '58		24b. REGISTRAR'S SIGNATURE Dee Smith			

CERTIFICATE OF DEATH

Page 1 of 1

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		FEB 18 1958	
AGE		SEX	
65		M	
RACE		EDUCATION	
W		H	
OCCUPATION		CAUSE OF DEATH	
RETIRED		HEART DISEASE	
PLACE OF DEATH		MANNER OF DEATH	
HOME		NATURAL	
CITY		COUNTY	
BALTIMORE		BALTIMORE	
STATE		FEDERAL BUREAU OF INVESTIGATION	
MD		FEB 20 1958	

BUREAU V. 1

FEB 20 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2517

CERTIFICATE OF DEATH

Reg. Dist. No.

02481

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u>				c. LENGTH OF STAY IN 1b <u>LIFE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ST. PAUL ST.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMMA AGUSTA KLINE</u>				4. DATE OF DEATH Month Day Year <u>FEBRUARY - 5 - 1958</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUGUST - 30 - 1883</u>	9. AGE (In years lost birthday) <u>74</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BOONSBORO WASH. Co. MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>GEORGE CARSON</u>			
14. MOTHER'S MAIDEN NAME <u>SOBMAN SOUDERS</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>NONIE</u>				17. INFORMANT <u>CHARLES M. KLINE</u> Address <u>BOONSBORO MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>4:20.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Feb 4</u> , 19 <u>58</u> , to <u>Feb 5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb 4</u> , 19 <u>58</u> , and that death occurred at <u>7 A</u> . M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED <u>Boonsboro</u> <u>2-6-58</u>							
ACTUAL SIGNATURE <u>G. W. LeVan</u> M.D.							
PHYSICIAN'S NAME (Type) <u>G. W. LeVan</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>							
22b. DATE THEREOF <u>FEB. 7, 1958</u>							
22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>							
22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. Co. MD</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Barth J. Mull Home</u>							
ADDRESS <u>BOONSBORO MD.</u>							
24a. REC'D BY REGISTRAR <u>Feb 10 '58</u>							
24b. REGISTRAR'S SIGNATURE <u>DeLoach</u>							

CERTIFICATE OF DEATH

BUREAU V. S.

FEB 10 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2488

CERTIFICATE OF DEATH

Reg. Dist. No.

02482

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		d. STREET ADDRESS <u>523 Liberty St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>LUTHER</u> Last <u>LANCASTER</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>4</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 6, 1872</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Williamsport, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William L. Lancaster</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth E. Taylor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Madiline Lancaster</u>		Address <u>523 Liberty St, Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>900.0 Cerebral concussion duration--9 days</u> INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>1 year (certain)</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>Patient fell down stairs.</u>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>10:00</u> a. m. <u>Jan. 27</u> 19 <u>58</u> m. <u> </u> <u> </u> <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Hagerstown Wash. Maryland</u>	
21. I certify that I attended the deceased from <u>January 28 1958</u> , to <u>February 4 19 58</u> that I last saw the deceased alive on <u>February 4</u> 19 <u>58</u> , and that death occurred at <u>7:15 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>100 Professional Arts Bldg.</u> DATE SIGNED <u>2/5/58</u> ACTUAL SIGNATURE <u>William T. Layman</u> M.D. <u>100 Professional Arts Bldg.</u> DATE SIGNED <u>2/5/58</u> PHYSICIAN'S NAME (Type) <u>William T. Layman</u> <u>Hagerstown</u> <u>Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/7/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel Inc.</u>		24a. REC'D BY REGISTRAR <u>1601 Penna. Ave.</u> <u>Hagerstown, Md.</u>	
24b. REGISTRAR'S SIGNATURE <u>Wm. A. Horst C. Pres.</u>		24c. DATE <u>FEB 10 '58</u>	

BUREAU V. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2489

CERTIFICATE OF DEATH

02483

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 6 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL SHARPSBURG d. STREET ADDRESS SHARPSBURG MD. ROUTE 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE UPTON LEATHERMAN				4. DATE OF DEATH Month Day Year FEBRUARY 12 1958 19			
5. SEX male		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 16 1877	
9. AGE (In years last birthday) yrs. 80		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		11. BIRTHPLACE (State or foreign country) MYERSVILLE FRED.CO.MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN LEATHERMAN				14. MOTHER'S MAIDEN NAME ELIZABETH GROSSNICKLE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address BRUCE LEATHERMAN SHARPSBURG MD. R.1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable brain infarct 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis DUE TO (c) Benign hypertrophy of the prostate						INTERVAL BETWEEN ONSET AND DEATH 1 week 5 Yr (?)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 1 , 19 58 , to Feb. 12 , 19 58 , that I last saw the deceased alive on Feb. 11 , 19 58 , and that death occurred at M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sharpsburg, Md. DATE SIGNED 2/14/58 ACTUAL SIGNATURE Walter H. Shealy M.D. PHYSICIAN'S NAME (Type) Walter H. Shealy M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF FEB 15 1958		22c. NAME OF CEMETERY OR CREMATORY GREENHILL CEMETERY		22d. LOCATION (City, town, or county) (State) WAYNESBORO PENNA.	
23. FUNERAL DIRECTOR'S SIGNATURE East End Home				ADDRESS Boonsboro Md.		24a. RECEIVED BY REGISTRAR Feb 19 58 DATE	
				24b. REGISTRAR'S SIGNATURE Alfred			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 11

Reg. Dist. No.

1. DATE OF DEATH

2. PLACE OF DEATH

3. NAME OF DECEASED

4. SEX

5. AGE

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. DATE OF REGISTRATION

12. PLACE OF REGISTRATION

13. SIGNATURE OF DECEASED

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF DECEASED

16. SIGNATURE OF DECEASED

17. SIGNATURE OF DECEASED

18. SIGNATURE OF DECEASED

19. SIGNATURE OF DECEASED

20. SIGNATURE OF DECEASED

21. SIGNATURE OF DECEASED

22. SIGNATURE OF DECEASED

23. SIGNATURE OF DECEASED

BUREAU V. 3

FEB 19 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02484

Reg. Dist. No.

2518

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PONDSVILLE		c. LENGTH OF STAY IN lb 15 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PONDSVILLE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SMITHSBURG MD. ROUTE 1				d. STREET ADDRESS SMITHSBURG MD. ROUTE 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last LEON DANIEL LEWIS				4. DATE OF DEATH Month Day Year FEBRUARY 18 1958 19			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DECEMBER 21 1915 42 yrs.	
9. AGE (in years last birthday)		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GRINDER MAGNUS METAL WORKS		10b. KIND OF BUSINESS OR INDUSTRY MYERSVILLE FRED. CO. MD.		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME EDWARD LEWIS			
14. MOTHER'S MAIDEN NAME EMMA HINES				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 217-12-2260				17. INFORMANT MRS. DORIS LEWIS SMITHSBURG MD. ROUTE 1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X acute cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. (c)</p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 322.2 Alcoholism							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -				20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. none 19			
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none			
20f. (City or town) -				20g. (County) -			
20h. (State) -				21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE S. Robert Wells				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) S. Robert Wells, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF FEB. 20 1958		22c. NAME OF CEMETERY OR CREMATORY SMITHSBURG CEMETERY	
22d. LOCATION (City, town, or county) SMITHSBURG MD.				22e. (State) MD.			
23. FUNERAL DIRECTOR'S SIGNATURE East End Home				ADDRESS Boonsboro Md.		24a. REC'D BY REGISTRAR DATE FEB 21 '58	
24b. REGISTRAR'S SIGNATURE W. J. Smith							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

FEB 21 1958

RECEIVED

2490

CERTIFICATE OF DEATH

Reg. Dist. No.

02485

1. PLACE OF DEATH a. COUNTY WASHINGTON		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 3 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KEEDYSVILLE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS MAIN STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last FOSTER J. LONG		4. DATE OF DEATH Month Day Year FEBRUARY 11 1958 19					
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 23 1880		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY B. and O. R. R. CO. MIDDLETOWN FRED. CO. MD.		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME WILLIAM COST LONG		14. MOTHER'S MAIDEN NAME FRANCES COFFMAN					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 705-07-7701		17. INFORMANT Gerald Long		Address Keedysville Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 430.0 pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/8/58 , 19____, to 2/11/58 , 19____, that I last saw the deceased alive on 2/10/58 , 19____, and that death occurred at 5 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 136 N. Potomac Street 2/12/58							
ACTUAL SIGNATURE Howard N. Weeks		M.D. 136 N. Potomac Street		DATE SIGNED 2/12/58			
PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.		Hagerstown, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF FEBRUARY 14 1958		22c. NAME OF CEMETERY OR CREMATORY BOONSBORO CEMETERY BOONSBORO WASH. CO. MD.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE East Funeral Home Boonsboro Md		ADDRESS		24a. REC'D BY REGISTRAR DATE FEB 19 '58		24b. REGISTRAR'S SIGNATURE W. L. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WILLIAM BOND

BUREAU V. 3

FEB 19 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3 Film G225 2-10-58 et

CERTIFICATE OF DEATH

02486

2491

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leitersburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>23 E. Antietam</u>		e. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Clarence</u> Middle <u>W. Lowman</u> Last <u>Kohman</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>3</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 19, 1899</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fairchild</u>		11. BIRTHPLACE (State or foreign country) <u>Leitersburg Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John J. Lowman</u>	
14. MOTHER'S MAIDEN NAME <u>Annie Kline</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>220-09-9153</u>		17. INFORMANT <u>Mrs. Mary Lowman, Leitersburg Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Failure</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitus</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 31</u> , 19 <u>58</u> , to <u>Feb 3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 31</u> , 19 <u>58</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David B. Hess</u> M.D.		ADDRESS (Street, city or town, state) <u>Shady Grove, Pa.</u>	
DATE SIGNED <u>2/3/58</u>		PHYSICIAN'S NAME (Type) <u>David B. Hess M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/6/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Leitersburg</u>		22d. LOCATION (City, town, or county) (State) <u>Leitersburg, Washington Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Shaw, Waynesboro Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 6 '58</u>	
24b. REGISTRAR'S SIGNATURE <u> </u>			

U. S. BUREAU

6 FEB 1967

RECEIVED

Reg. Dist. No. 02487

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BENEVOLA				c. LENGTH OF STAY IN 1b 35 YEARS							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION BOONSBORO MD. ROUTE 1						e. IS RESIDENCE ON A FARM? YES [] NO [X]					
3. NAME OF DECEASED (Type or print) PEARL A. LUM						4. DATE OF DEATH FEBRUARY 28 1958 19					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED [X] NEVER MARRIED [] WIDOWED [] DIVORCED []		8. DATE OF BIRTH SEPT. 7 1879		9. AGE (In years last birthday) yrs. 78		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE						10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) ZITTELTOWN WASH. CO. MD. U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JOHN MITCHELL						14. MOTHER'S MAIDEN NAME SUSAN ZITTLE					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO NONE				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address CALVIN A. LUM BOONSBORO MD. ROUTE 1					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease 10 yr. DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES [] NO [X]											
20a. ACCIDENT WAS UNDERLYING [] OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED White Nat while of work [] of work []		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Feb. 27 1958, to Feb. 28 1958, that I last saw the deceased alive on Feb. 27 1958, and that death occurred at 7:30P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED B.B. Kneisley M.D. 148 West Washington Street 3/1/58 Hagerstown, Maryland											
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF MARCH 3 1958		22c. NAME OF CEMETERY OR CREMATORY BOONSBORO CEMETERY		22d. LOCATION (City, town, or county) (State) BOONSBORO WASH. CO. MD.			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS B.B. Kneisley, M.D. Hagerstown, Maryland						24a. REC'D BY REGISTRAR DATE MAR 5 '58		24b. REGISTRAR'S SIGNATURE			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. B.

MAR 5 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG225 2-11-58 et

2520

CERTIFICATE OF DEATH

02488

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Bethesda</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>				d. STREET ADDRESS <u>1 Old Hanover Rd.</u>					
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>A</u> Last <u>McDonald</u>				4. DATE OF DEATH Month <u>February</u> Day <u>1</u> Year <u>1958</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 26, 1875</u>			
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>15</u> Min.		IF UNDER 24 HRS. Months <u>1</u> Days <u>1</u> Hours <u>15</u> Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>light Inspector</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>William Thomas McDonald</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ellen Sparrow</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Gillian M. McDonald, 1 Old Hanover Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carnary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>								INTERVAL BETWEEN ONSET AND DEATH <u>minute</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> Month <u></u> Day <u></u> Year <u></u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <u>Jan 2</u> , 19 <u>58</u> , to <u>Feb 1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb 1</u> , 19 <u>58</u> , and that death occurred at <u>10:57</u> M, from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Paul Hank</u> M.D.				ADDRESS (Street, city or town, state) <u>2846 Tofornac Street</u> DATE SIGNED <u>1 Feb 58</u>					
PHYSICIAN'S NAME (Type) <u>Paul Hank</u> M.D. <u>Williamsport, Md.</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-4-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudoun Park</u>		22d. LOCATION (City, town, or county) (State) <u>Catonsville Md -</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>George A. Thesbaum</u> ADDRESS <u></u>				24a. REC'D BY REGISTRAR DATE <u>FEB 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Beach</u>			

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN lb <u>8 yrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown Md.</u>			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Hazel</u> Last <u>Mc Ginley</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>8</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 11 1900</u>	
9. AGE (In years last birthday) <u>57 yrs.</u>		IF UNDER 1 YEAR Months <u>10</u> Days <u>27</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Williamsport Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Pettit</u>				14. MOTHER'S MAIDEN NAME <u>Agnes Harsh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		17. INFORMANT <u>Mr. William Mc Ginley</u> Address <u>109 Ray St. Hagerstown Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Skull</u> 816 X DUE TO <u>Fractured zygoma (lt)</u> Conditions, if any, which gave rise to immediate cause (b) <u>Fractured lt hip (closed)</u> (a), stating the underlying cause last. DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger in auto that made a left turn in front of oncoming car.</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>12:30</u> <u>PM</u> <u>Feb. 7 1958</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) (County) (State) <u>Hagerstown Wash Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 11-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Williamsport Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edith V. Leaf Williamsport Md</u>				24a. REC'D BY REGISTRAR <u>FEB 14 '58</u> 24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. B.

FEB 14 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02490

2493

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 46 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 859 Dewey Ave.				1 d. STREET ADDRESS 859 Dewey Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Calvin Last Meyers				4. DATE OF DEATH Month Feb. Day 9 Year 19 58			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1881		9. AGE (In years last birthday) yrs. 76	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY farm		11. BIRTHPLACE (State or foreign country) Franklin Co., Penna.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Noah Meyers				14. MOTHER'S MAIDEN NAME Sarah Zimmerman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. --		17. INFORMANT Address Iva M. Meyers, Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiovascular Disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 5 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11-1-57 , 19____, to 2-9- , 19 58 , that I last saw the deceased alive on 2-8-58 , 19____, and that death occurred at 11 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature]				ADDRESS (Street, city or town, state) Hagerstown Md		DATE SIGNED 2/14/58	
PHYSICIAN'S NAME (Type) [Signature]				M.D. [Signature]		DATE SIGNED 2/14/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 2-12-58		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Greencastle, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.				ADDRESS [Address]		24a. REC'D BY REGISTRAR Feb 13 1958	
				24b. REGISTRAR'S SIGNATURE [Signature]			

CERTIFICATE OF DEATH

NAME OF DECEASED John Calvin Meyers		SEX Male	
DATE OF BIRTH May 12, 1881		AGE 47 years	
PLACE OF BIRTH Hagerstown, Maryland		RACE White	
OCCUPATION Farmer		CAUSE OF DEATH (To be filled by physician)	
PLACE OF DEATH Hagerstown, Maryland		TIME OF DEATH (To be filled by physician)	
NAME OF PHYSICIAN (To be filled by physician)		SIGNATURE OF PHYSICIAN (To be filled by physician)	
NAME OF FUNERAL HOME (To be filled by funeral home)		SIGNATURE OF FUNERAL HOME (To be filled by funeral home)	
NAME OF NEXT OF KIN (To be filled by next of kin)		SIGNATURE OF NEXT OF KIN (To be filled by next of kin)	
NAME OF CORONER (To be filled by coroner)		SIGNATURE OF CORONER (To be filled by coroner)	
NAME OF REGISTRAR (To be filled by registrar)		SIGNATURE OF REGISTRAR (To be filled by registrar)	

RECEIVED
 BUREAU V. E.
 FEB 18 1958

JOSEPH T. WINNICH & SON, HAGERSTOWN, MD.

2494

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 3 wks.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM HENRY CLAY MILLER, SR.				4. DATE OF DEATH Month Day Year February 3, 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 31, 1889	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Warehouse Foreman-W. Md. Railway				10b. KIND OF BUSINESS OR INDUSTRY Ellerton, Fred. Co., Md.		11. BIRTHPLACE (State or foreign country) USA	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME George Miller				14. MOTHER'S MAIDEN NAME Emma Kitzmiller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 705-10-5194			
17. INFORMANT Mrs. Hilda S. Miller-719 Washington A.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 DUE TO Cirrhosis of Liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 3/12/57 , 19____, to 2/3/58 , 19____, that I last saw the deceased alive on 2/3/58 , 19____, and that death occurred at 12:40 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Howard N. Weeks, M.D. 136 North Potomac Street 2/3/58							
ACTUAL SIGNATURE Howard N. Weeks, M.D.				PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2-5-58		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	
22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman-Hagerstown, Maryland				24a. REC'D BY REGISTRAR FEB 7 '58		24b. REGISTRAR'S SIGNATURE Al. Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WESTLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

BUREAU V. 8

FEB 7 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02492

2521

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>wash.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. LENGTH OF STAY IN 1b <u>9 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boonsboro</u> <u>Route 1</u>			
f. STREET ADDRESS <u>Boonsboro</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>E</u> Last <u>Moats</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>16</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 17, 1889</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Edward Lambert</u>	
14. MOTHER'S MAIDEN NAME <u>Lillie Smith</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Leslie J. Moats</u> Address <u>Boonsboro, Md. R1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO _____				INTERVAL BETWEEN ONSET AND DEATH <u>27 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>1/11</u> 19 <u>58</u> , to <u>Feb 16</u> 19 <u>58</u> , that I last saw the deceased alive on <u>14 Feb</u> 19 <u>58</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul Hank</u> M.D.				ADDRESS (Street, city or town, state) <u>2801 W. Potomac Street</u> DATE SIGNED <u>17 Feb 58</u>			
PHYSICIAN'S NAME (Type) <u>PAUL HANK, M.D.</u>				<u>Williamsport, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>FEB. 20 1958</u>		<u>SMITHSBORO CEMETERY</u>		<u>SMITHSBORO, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME</u>				ADDRESS <u>BOONSBORO MD</u>		24a. REC'D BY REGISTRAR <u>Feb 21 58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. J. Leach</u>				DATE			

BUREAU V. S.

1958 12 28

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2522

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cascade</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cascade</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lewis</u> Middle <u>Jacob</u> Last <u>Moore</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>1</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/25/1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		11. BIRTHPLACE (State or foreign country) <u>Cascade Md.</u>	
13. FATHER'S NAME <u>John Marshall Moore</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jane Royer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>189-18-6087</u>	
17. INFORMANT <u>Mrs. Lewis Moore</u>		Address <u>Cascade Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension - Arteriosclerotic heart disease</u> (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>12-18 hrs</u> <u>3-5 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1 June</u> , 19 <u>57</u> , to <u>1 Feb</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>31 January</u> , 19 <u>58</u> , and that death occurred at <u>5:30 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Blue Ridge Summit Pa</u> DATE SIGNED <u>3 Feb 1958</u> ACTUAL SIGNATURE <u>Harry H. Young Jr.</u> M.D. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/4/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bethel</u>		22d. LOCATION (City, town, or county) (State) <u>Lantz #1 Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Y. Grove, Waynesboro Pa.</u>		24a. REC'D BY REGISTRAR <u>FEB 6 '58</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>W. Y. Grove</u>			

BUREAU V. 3

FEB 6 1958

RECEIVED

2495

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
c. LENGTH OF STAY IN 1b 31 years		d. STREET ADDRESS 439 W. Washington Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 439 W. Washington Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle Elizabeth Last MOORE		4. DATE OF DEATH Month February Day 1 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 13, 1886
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 9 Days 18 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Hagerstown, Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Mc Carter		14. MOTHER'S MAIDEN NAME Eleanor Fridinger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. Thomas H. Moore		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aortic stenosis DUE TO (c) Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-21 , 1958, to 2-1 , 1958, that I last saw the deceased alive on 2-1 , 1958, and that death occurred at 7:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE John D. Torco M.D.			
PHYSICIAN'S NAME (Type) JOHN D. TORCO			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/4/1958	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE R. Franklin Boyer		24a. REC'D BY REGISTRAR DATE FEB 5 1958	
ADDRESS Hagerstown, Md.		24b. REGISTRAR'S SIGNATURE Rebecca	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2496

CERTIFICATE OF DEATH

02495

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>18 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>SAMUEL</u> Middle <u>B</u> Last <u>RAINEY</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>11</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 13, 1903</u>	9. AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bus Driver</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Transportation</u>			11. BIRTHPLACE (State or foreign country) <u>Turner Co. Georgia</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel L. Rainey</u>				14. MOTHER'S MAIDEN NAME <u>Mary Hogan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>214-10-4997</u>		17. INFORMANT <u>Mrs. Samuel B. Rainey</u> Address <u>1048 Fairview Rd. Hagerstown</u> Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July</u> , 19 <u>55</u> , to <u>Feb 11</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb 11</u> , 19 <u>58</u> , and that death occurred at <u>11:00</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Elyse A. Hoffman</u> M.D. <u>214 N. Potomac St.</u>							
PHYSICIAN'S NAME (Type) <u>Elyse A. Hoffman</u> <u>Hagerstown, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/14/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel Inc.</u>				ADDRESS <u>1601 Penna. Ave. Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>Feb 18 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Wm. A. Hunt</u>			

RECEIVED

FEB 18 1958

BUREAU V. 31

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 shows, be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2497 Item 14 Film G225 2-19-58 et
CERTIFICATE OF DEATH

02496

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>425 George Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>KATHRYN ELEANOR REYNOLDS</u>				4. DATE OF DEATH Month Day Year <u>February 9 19 58</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 25, 1897</u>	
9. AGE (In years lost birthday) <u>60 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Washington County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Berger</u>				14. MOTHER'S MAIDEN NAME <u>Anna May Daymude</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>William J. Reynolds Hagerstown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>Carcinoma Bronchus - Left</u> <u>162.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <u>Jan 6 1958</u> , to <u>Feb 9 1958</u> , that I last saw the deceased alive on <u>Jan 6 1958</u> , and that death occurred at <u>6:00</u> M., from the causes and on the date stated above. ADDRESS (Street, City or town, State) DATE SIGNED ACTUAL SIGNATURE <u>Philip J. Hirshman</u> M.D. <u>159 W. Washington St. Hagerstown, Md.</u> <u>2/10/58</u> PHYSICIAN'S NAME (Type) <u>Philip J. Hirshman, M.D. 159 W. Washington St., Hagerstown, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/12/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Boyer</u>				ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 13 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. J. Reynolds</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02497

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. STREET ADDRESS 350 EAST WASHINGTON ST	
3. NAME OF DECEASED (Type or print) First COLUMBUS Middle VICTOR Last RIDENOUR		4. DATE OF DEATH Month 2 Day 20 Year 19 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 4, 1891
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR		10b. KIND OF BUSINESS OR INDUSTRY CREAMERY CO.	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME SAMUEL RIDENOUR	
14. MOTHER'S MAIDEN NAME EDITH STEFFEY		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. 219-20-2085		17. INFORMANT MRS. HARRIETT RIDENOUR Address HAGERSTOWN, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Myocardial heart disease DUE TO Acute Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m. none		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) - (County) - (State) -	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/22/58	
22c. NAME OF CEMETERY OR CREMATORY ROSE HILL		22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE FRED W. KRAISS		ADDRESS HAGERSTOWN, MD.	
24a. REC'D BY REGISTRAR FEB 24 '58		24b. REGISTRAR'S SIGNATURE W. J. ...	

BUREAU V. S.

FEB 24 1963

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02498

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. LENGTH OF STAY IN 1b <u>47 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Williamsport</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>19 North Vermont Street</u>				d. STREET ADDRESS <u>19 North Vermont Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Helena</u> Middle <u>Mae</u> Last <u>Rockwell</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>12</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 4 1910</u>	9. AGE (In years last birthday) <u>47</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>7</u>	IF UNDER 24 HRS. Hours <u>7</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sanitress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tannery</u>		11. BIRTHPLACE (State or foreign country) <u>Williamsport Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Bowers</u>				14. MOTHER'S MAIDEN NAME <u>Emma May Forsthye</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-056296</u>		17. INFORMANT Address <u>19 Vermont St. Williamsport Md.</u> <u>Mr. Morrison Rockwell</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>acute coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH, <u>10 MIN.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>None</u> p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>S. Robert Wells M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Feb. 13 1958</u>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 15-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Williamsport Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf Williamsport Md.</u>				24a. REC'D BY REGISTRAR DATE _____		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

FEB 14 1959

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2499

CERTIFICATE OF DEATH

02499

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 10 min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERT Middle EMORY Last ROWE		4. DATE OF DEATH Month February Day 24 , Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 15, 1884
9. AGE (In years last birthday) yrs. 73		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Filling Station Operator-Self Empl.		10b. KIND OF BUSINESS OR INDUSTRY Hagerstown, Maryland	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph E. Rowe		14. MOTHER'S MAIDEN NAME Nannie Troxell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 215-26-0831	
17. INFORMANT Mrs. Mary Fox Rowe		Address 433 George St. Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Hypertensive Cardio Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 5 yr DUE TO (c) 5 yr			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-1- 1957 , to 2-24- 1958 , that I last saw the deceased alive on 1-7-58 , 19 58 , and that death occurred at 1:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hagerstown, Md. DATE SIGNED 7/29/58			
ACTUAL SIGNATURE S. R. Coffman		M.D. Hagerstown, Md.	
PHYSICIAN'S NAME (Type) S. R. Coffman		DATE SIGNED 7/29/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-27-58	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown, Wash. Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		ADDRESS Hagerstown, Maryland	
24a. REC'D BY REGISTRAR Feb 28 '58		24b. REGISTRAR'S SIGNATURE Dee Leach	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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CERTIFICATE OF DEATH

NEWARK STATE DEPARTMENT OF HEALTH-BUREAU 18

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

BUREAU V. 3

FEB 28 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2524

Item 8 Film G225 2-19-58 et
CERTIFICATE OF DEATH

Reg. Dist. No.

02500

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown				c. LENGTH OF STAY IN 1b 4 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS Route 6			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Anna Middle Bertha Last Rowland				4. DATE OF DEATH Month February Day 7 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 30, 1878	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Franklin County Pa.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Jacob Haugh				14. MOTHER'S MAIDEN NAME Mary Gerhart			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. ---		17. INFORMANT Mrs. Carl Schlotterbeck Hagerstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 902.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic Heart Disease 5 yr (c) Fracture Neck of Humerus 3 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell off end of porch					
20c. TIME OF INJURY Hour a. m. 4 p. m. Month 3/4/58 Day 19 Year 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Hagerstown Pa Washington Md	
21. I certify that I attended the deceased from 11-1-57 , to 2-7-58 , that I last saw the deceased alive on 2-7-58 , and that death occurred at 4 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE E. W. Ditto Jr.				ADDRESS (Street, city or town, state) DATE SIGNED 215 W. Washington Hag. Md. 2/9/58			
PHYSICIAN'S NAME (Type) E. W. Ditto Jr.				215 W Washington Hag Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-10-58		22c. NAME OF CEMETERY OR CREMATORY Beautiful View		22d. LOCATION (City, town, or county) (State) Middleburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son Hagerstown Md.				24a. REC'D BY REGISTRAR FEB 13 '58		24b. REGISTRAR'S SIGNATURE Per [Signature]	

CONCLUSION

0510-1

INDEX

22-0151-10

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2525

CERTIFICATE OF DEATH

Reg. Dist. No.

02501

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Smithsburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Smithsburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD #1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Elsie May Schofield				4. DATE OF DEATH Month Feb. Day 17, Year 1958			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 14, 1876	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months 6 Days 10		IF UNDER 24 HRS. Hours 15 Min. 2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ashland, Ky	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME Henry Riley			
14. MOTHER'S MAIDEN NAME Roberts				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			
16. SOCIAL SECURITY NO.				17. INFORMANT Mrs. Ethelbert S. Robinson, Smithsburg			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) Chronic Cirrhosis Generalized DUE TO (c) Carcinoma Body of uterus				INTERVAL BETWEEN ONSET AND DEATH 6 wks 15 yrs 1 yr			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 9. p. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Smithsburg				20g. (County) Washington		20h. (State) Md.	
21. I certify that I attended the deceased from Feb 14, 1958 to Feb 17, 1958 , that I last saw the deceased alive on Feb 17, 1958 , and that death occurred at 4:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Smithsburg Md DATE SIGNED 2-18-58							
ACTUAL SIGNATURE G. A. K. O. L. E. R. M.D.				PHYSICIAN'S NAME (Type) G. A. K. O. L. E. R.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-21-58		22c. NAME OF CEMETERY OR CREMATORY Lakewood Mem. Gardens		22d. LOCATION (City, town, or county) (State) Dorseyville, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.				24a. REC'D BY REGISTRAR DATE FEB 21 '58		24b. REGISTRAR'S SIGNATURE W. H. H. H.	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

FEB 21 1953

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2500

CERTIFICATE OF DEATH

Reg. Dist. No. 2502

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS 1141 Fairview Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last LEONA F SCRANTON		4. DATE OF DEATH Month Day Year Feb. 22 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1880
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Philadelphia, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Leslie B. Farmer		14. MOTHER'S MAIDEN NAME Mabel W. Beckenbridge	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT J.H. Scranton		Address 1141 Fairview Rd. Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) Cerebral thrombosis		INTERVAL BETWEEN ONSET AND DEATH 3 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1955, to 1958, that I last saw the deceased alive on 2/22, 1958, and that death occurred at M, from the causes and on the date stated above.			
ACTUAL SIGNATURE H. N. Weeks		ADDRESS (Street, city or town, state) 136 N. Palmer	
PHYSICIAN'S NAME (Type) HOWARD N. WEEKS		DATE SIGNED 2/24/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/25/58	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Best Haven Funeral Chapel Inc.		ADDRESS 1601 Penna. Ave. Hagerstown, Md.	
24a. REC'D BY REGISTRAR DATE FEB 27 '58		24b. REGISTRAR'S SIGNATURE	

FEB 27 1958

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FEB 27 1958

2501

CERTIFICATE OF DEATH

02503

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garlock Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. DATE OF DEATH Month 2 Day 28 Year 19 58		d. STREET ADDRESS Piper Lane	
3. NAME OF DECEASED (Type or print) First Lula Middle Lee Last Shafer		4. DATE OF DEATH Month 2 Day 28 Year 19 58	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 17, 1888
9. AGE (In years last birthday) 69		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Wash. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Lee Smith		14. MOTHER'S MAIDEN NAME Mollie Mongan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Clyde Fleagle		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease. 4437 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 1, 1957 , to Feb. 28, 1958 , that I last saw the deceased alive on Feb. 28, 1958 , and that death occurred at 9:15 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 119 North Potomac St. Hagerstown, Maryland. DATE SIGNED 3-1-58			
ACTUAL SIGNATURE R.A. Bell		M.D. 3-1-58	
PHYSICIAN'S NAME (Type) R.A. Bell, M.D.		Hagerstown, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-3-58	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill		22d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR MAR 4 '58		24b. REGISTRAR'S SIGNATURE R. A. Bell	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

Form 10-4-10

NAME OF DECEASED		DATE OF DEATH	
J. M. HARRIS		JAN 15 1958	
PLACE OF DEATH		AGE	
HARRIS		63	
OCCUPATION		SEX	
LABORER		M	
EDUCATION		RACE	
8 YEARS		W	
MARRIAGE		RELIGION	
MARRIED		METHODIST	
DATE OF MARRIAGE		PLACE OF BIRTH	
JAN 15 1900		BALTIMORE, MD	
CAUSE OF DEATH		MANNER OF DEATH	
HEART DISEASE		NATURAL	
IMMEDIATE CAUSE		INTERMEDIATE CAUSE	
CORONARY THROMBOSIS		HYPERTENSION	
PREVIOUS ILLNESS		PREVIOUS SURGERY	
NONE		NONE	
DATE OF EXAMINATION		PLACE OF EXAMINATION	
JAN 15 1958		BALTIMORE, MD	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
J. M. HARRIS		J. M. HARRIS	

BUREAU V. S.

MAR 4 1958

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2502

CERTIFICATE OF DEATH

02504

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middletown</u> 10X 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>		d. STREET ADDRESS <u>W. Main St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>E.</u> Last <u>Shank</u>		4. DATE OF DEATH Month <u>2</u> Day <u>21</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/26/1912</u>
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ice cream plant</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Martin L. Shank</u>		14. MOTHER'S MAIDEN NAME <u>Alda Carson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-03-0145</u>	
17. INFORMANT <u>Mrs. Catherine Shank</u>		Address <u>Middletown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inanition</u> <u>200.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>secondary to lymphosarcoma, stomach with</u> DUE TO <u>generalized abdominal metastasis.</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u> <u>1 1/2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-258</u> , 19 <u>58</u> , to <u>2-21-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2-21-58</u> , 19 <u>58</u> , and that death occurred at <u>10:55 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>John H. Kehne</u>		M.D.	
PHYSICIAN'S NAME (Type) <u>Dr. John H. Kehne</u>		<u>131 West Washington Street, Hag., Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>2/23/1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Middletown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Co., Middletown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 25 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Alfred</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF DEATH [Faint text]		PLACE OF DEATH [Faint text]		COUNTY [Faint text]	
TIME OF DEATH [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
PLACE OF BIRTH [Faint text]		DATE OF BIRTH [Faint text]		SEX [Faint text]	
OCCUPATION [Faint text]		EDUCATION [Faint text]		RELIGION [Faint text]	
MARITAL STATUS [Faint text]		PREVIOUS MARRIAGES [Faint text]		PREVIOUS DEATHS [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF CORONER [Faint text]		SIGNATURE OF JURY [Faint text]		SIGNATURE OF JUDGE [Faint text]	

BUREAU V. 5

FEB 25 1998

RECEIVED

2503

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 24 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS 14 Berner Ave.	
3. NAME OF DECEASED (Type or print) HYMOND EDWARD SHARON		4. DATE OF DEATH Month February Day 2 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25, 1888
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 6 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman - Hagerstown Rubber Co.		10b. KIND OF BUSINESS OR INDUSTRY Magnola-Morgan Co.	
11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph W. Sharon		14. MOTHER'S MAIDEN NAME Florence Hare	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-09-7655	
17. INFORMANT Mrs. Etta G. Sharon		Address 14 Berner Av.	
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 334x DUE TO Cerebral Arterio Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Cerebral Arterio Sclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 18 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 2 1958 to Feb 2 1958 that I last saw the deceased alive on Feb 2 1958 , and that death occurred at 10 P. M. from the causes and on the date stated above. ACTUAL SIGNATURE J. H. Beachley M.D. ADDRESS (Street, city, town, state) Hagerstown, Md DATE SIGNED Feb 7 1958 PHYSICIAN'S NAME (Type) J. H. Beachley			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-5-58	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		24a. REC'D BY REGISTRAR FEB 7 1958	
ADDRESS Hagerstown, Maryland		24b. REGISTRAR'S SIGNATURE W. Beachley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WILLIAM W. BOND



BUREAU V. 2

FEB 7 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02596

2526

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Weverton		c. LENGTH OF STAY IN 1b 45 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Residence		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle PRESTON Last SPICKLER		4. DATE OF DEATH Month February Day 16 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 1, 1875
9. AGE (In years last birthday) yrs. 82		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railway Mail Clerk		10b. KIND OF BUSINESS OR INDUSTRY Post office Dept. Cearfoss, Md.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Franklin P. Spickler		14. MOTHER'S MAIDEN NAME Catherine Myers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give year or dates of service) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Ruth G. Spickler		18. ADDRESS R.F.D. # 1, Knoxville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/22 , 19 57 , to 2/16 , 19 58 , that I last saw the deceased alive on 2/15 , 19 58 , and that death occurred at 6:00 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. B. Carpenter, MD		ADDRESS (Street, city or town, state) Lovettsville, Va.	
PHYSICIAN'S NAME (Type) W. B. Carpenter, MD		DATE SIGNED 2/18/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/19/58	
22c. NAME OF CEMETERY OR CREMATORY Broadfording Cemetery		22d. LOCATION (City, town, or county) (State) Broadfording, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Donald Backles		24a. REC'D BY REGISTRAR FEB 20 58	
ADDRESS Harpers Ferry, West Va.		24b. REGISTRAR'S SIGNATURE W. B. Carpenter	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		45		M		W		1880		BALTIMORE		BALTIMORE		MARYLAND	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE		COUNTRY OF MARRIAGE	
Carpenter		High School		Married		Roman Catholic		1905		BALTIMORE		BALTIMORE		MARYLAND	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT		CITY OF INTERMENT		COUNTRY OF INTERMENT	
Feb 20 1958		Home		BALTIMORE		MARYLAND		Feb 22 1958		CATHOLIC CHURCH		BALTIMORE		MARYLAND	
CAUSE OF DEATH		MANNER OF DEATH		DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY OF EXAMINATION		COUNTRY OF EXAMINATION		DATE OF SIGNATURE		PLACE OF SIGNATURE	
Heart Disease		Natural		Feb 18 1958		BALTIMORE		BALTIMORE		MARYLAND		Feb 18 1958		BALTIMORE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE		COUNTRY OF SIGNATURE		DATE OF SIGNATURE		PLACE OF SIGNATURE	
J. H. Harris		J. H. Harris		Feb 18 1958		BALTIMORE		BALTIMORE		MARYLAND		Feb 18 1958		BALTIMORE	

BUREAU V. 3

FEB 20 1958

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02507

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 20 East Ave		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Arthur Carroll Stauffer		4. DATE OF DEATH Month February Day 20 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 24, 1897
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Worker		10b. KIND OF BUSINESS OR INDUSTRY School	
11. BIRTHPLACE (State or foreign country) Hagerstown Md.		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME William H. Stauffer		14. MOTHER'S MAIDEN NAME Siretha Duncan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W. W. 1		16. SOCIAL SECURITY NO. 214-09-5673	
17. INFORMANT Harry Monninger Sr.		Address Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. none 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	20f. (City or town) (County) (State) - - -
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Samuel R. Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-22-58	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR DATE FEB 24 '58		24b. REGISTRAR'S SIGNATURE [Signature]	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
 HEALTH DEPT

Washington		Baltimore	
20 East Ave		20 East Ave	
Male		Male	
White		White	
High School		High School	
William F. Stanger		William F. Stanger	
1911-09-26		1911-09-26	
Baltimore, Md.		Baltimore, Md.	
U. S. A.		U. S. A.	

Bureau of Health		Bureau of Health	
Baltimore, Md.		Baltimore, Md.	
U. S. A.		U. S. A.	

BUREAU V. S.

FEB 24 1938

RECEIVED

George T. Manning & Son - Baltimore, Md.		George T. Manning & Son - Baltimore, Md.	
Bureau of Health		Bureau of Health	
Baltimore, Md.		Baltimore, Md.	
U. S. A.		U. S. A.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02508

Reg. Dist. No.

2527

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport Md RFD 2</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Williamsport Md. RFD #2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kemps Mill</u>		d. STREET ADDRESS <u>Kemps Mill</u>	
3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>Pearl</u> Last <u>Taylor</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 21 1883</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR: Months <u>5</u> Days <u>14</u> Hours <u></u> Min. <u></u> IF UNDER 24 HRS. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Tilghmanton Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Elias Smith</u>		14. MOTHER'S MAIDEN NAME <u>Laura Potterfield</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Gustavus Caplett Downsville Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Codwary Thrombosis</u> <u>Immediate</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/4/58</u> 19 to <u>2/5/58</u> 19, that I last saw the deceased alive on <u>2/5/58</u> , 19, and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Williamsport Md</u> DATE SIGNED <u>2/5/58</u>			
ACTUAL SIGNATURE <u>Robert Young</u> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 8 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Manor Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Near Tilghmanton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf</u>		24a. REC'D BY REGISTRAR <u>Feb 7 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>			

RECEIVED
FEB 7 1958
BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2505

CERTIFICATE OF DEATH

Reg. Dist. No.

02509

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b LIFE	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN		d. STREET ADDRESS 241 S. LOCUST ST.	
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CORA Middle M. Last UNGER		4. DATE OF DEATH Month FEBRUARY Day 19 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/1/1878
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR: Months 79 Days 19 Hours 58 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MARTIN L. UNGER		14. MOTHER'S MAIDEN NAME NANCY ENTLER FOUKE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MR. RALPH HIGGS		HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 31, 1953 , to Feb. 19, 1958 , that I lost saw the deceased olive on Feb. 19, 1958 , and that death occurred at 3:50 p.m. , from the causes and on the date stated above.			
ACTUAL SIGNATURE L. L. Packer		ADDRESS (Street, city or town, state) 145 W. Washington DATE SIGNED 2/21/58	
PHYSICIAN'S NAME (Type) L. L. Packer MD		Hagerstown Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2/22/58	22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.	
22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.		23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment, Hagerstown, Md.	
24a. REC'D BY REGISTRAR DATE FEB 24 '58		24b. REGISTRAR'S SIGNATURE Alfred Smith	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male	
3. AGE 68		4. DATE OF BIRTH 1887	
5. PLACE OF BIRTH BALTIMORE, MARYLAND		6. OCCUPATION Retired	
7. MARITAL STATUS Married		8. DATE OF DEATH FEB 24 1958	
9. PLACE OF DEATH Home		10. CAUSE OF DEATH Heart Disease	
11. MEDICAL HISTORY Hypertension, Atherosclerosis		12. SIGNATURE OF PHYSICIAN J. H. HARRIS	
13. SIGNATURE OF WITNESS J. H. HARRIS		14. SIGNATURE OF REGISTRAR J. H. HARRIS	

BUREAU V. F.

FEB 24 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2528

CERTIFICATE OF DEATH

Reg. Dist. No.

02510

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>			
c. LENGTH OF STAY IN 1b <u>3 years</u>				d. STREET ADDRESS <u>154 W. Franklin Street</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gateway Convalescent Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CLARINE</u> Middle <u>V.</u> Last <u>WARNER</u>				4. DATE OF DEATH Month <u>February</u> Day <u>7</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 6, 1860</u>	
9. AGE (In years last birthday) <u>97 yrs.</u>		IF UNDER 1 YEAR Months <u>9</u> Days <u>1</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George Bloom</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Shoop</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Clarine Garmong Hagerstown, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Heart Dis.</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491x Broncho pneumonia (1 mo. ago)</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>June 15, 1957</u> to <u>Feb. 7, 1958</u> , that I last saw the deceased alive on <u>Feb. 6, 1958</u> , and that death occurred at <u>4:19 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David R. Brewer</u> M.D.				ADDRESS (Street, city or town, state) <u>Clear Spring Md.</u>			
DATE SIGNED <u>2/7/58</u>							
PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/10/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Page</u>				ADDRESS <u>Hagerstown, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 10 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Alf. Smith</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEB 10 1953

RECEIVED

2506

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 5 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last NILE WEBB SR.		4. DATE OF DEATH Month Day Year FEBRUARY 1 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/30/1892
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MINISTER		10b. KIND OF BUSINESS OR INDUSTRY CHURCH	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES WEBB		14. MOTHER'S MAIDEN NAME LENORA DECKER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-14-7950	
17. INFORMANT MRS. ANNA B. WEBB		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 463x Pulmonary Embolism DUE TO Phlebotrombosis - Saphenous vein Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary embolism DUE TO (c) Pericarditis Constrictive			INTERVAL BETWEEN ONSET AND DEATH 3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug 13, 1957 to Feb 1st, 1958 that I last saw the deceased alive on Jan 31, 1958 and that death occurred at 8:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Philip J. Hirshman		ADDRESS (Street, city or town, state) 159 W Washington St, Hagerstown MD DATE SIGNED 2/3/58	
PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D. 159 W. Washington St., Hagerstown, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2/4/58	22c. NAME OF CEMETERY OR CREMATORY HILLCREST CEM.	22d. LOCATION (City, town, or county) (State) CUMBERLAND MD.
23. FUNERAL DIRECTOR'S SIGNATURE W. T. Horner		24. REC'D BY REGISTRAR DATE FEB 5 '58	
ADDRESS Hagerstown, Md.		24b. REGISTRAR'S SIGNATURE W. Deane	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

BUREAU V. 1

FEB 5 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2529

CERTIFICATE OF DEATH

02512

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FUNKSTOWN				c. LENGTH OF STAY IN 1b 2 YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 29 CEMETERY ST.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LOUIS Middle MARTIN Last WEILBACHER				4. DATE OF DEATH Month 2 Day 13 Year 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 1, 1880	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER				10b. KIND OF BUSINESS OR INDUSTRY SHIP YARD		11. BIRTHPLACE (State or foreign country) NEW JERSEY	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. I52-07-7477		17. INFORMANT CATHRYN GREENE I415 OAK TREE ROAD ISELIN, N.J.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mesenteric Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic Heart Disease DUE TO (c) Coronary Atherosclerosis				INTERVAL BETWEEN ONSET AND DEATH 24 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from FEB 13, 1958 , to FEB 13, 1958 , that I last saw the deceased alive on FEB 13, 1958 , and that death occurred at 12:20 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE SIDNEY ROBERTS M.D.				ADDRESS (Street, city or town, state) FUNKSTOWN MD			
DATE SIGNED 2-14-58							
PHYSICIAN'S NAME (Type) SIDNEY ROBERTS							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/17/58		22c. NAME OF CEMETERY OR CREMATORY NEW YORK BAY CEMETERY		22d. LOCATION (City, town, or county) (State) JERSEY CITY HUDSON N.J.	
23. FUNERAL DIRECTOR'S SIGNATURE FRED W. KRAISS				ADDRESS HAGERSTOWN, MD.		24a. REC'D BY REGISTRAR DATE FEB 20 '58	
24b. REGISTRAR'S SIGNATURE W. DeLoach							

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

REG. NO. 100

<p>1. NAME OF DECEASED _____</p>		<p>2. SEX _____</p>		<p>3. AGE _____</p>	
<p>4. DATE OF DEATH _____</p>		<p>5. TIME OF DEATH _____</p>		<p>6. PLACE OF DEATH _____</p>	
<p>7. CAUSE OF DEATH _____</p>		<p>8. MANNER OF DEATH _____</p>		<p>9. SIGNATURE OF PHYSICIAN _____</p>	
<p>10. SIGNATURE OF REGISTRAR _____</p>		<p>11. SIGNATURE OF WITNESS _____</p>		<p>12. SIGNATURE OF DECEASED _____</p>	

BUREAU V. 3

FEB 20 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2507

CERTIFICATE OF DEATH

02513
302

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. county Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>SAMUEL KIMMEL WELCH</u>				4. DATE OF DEATH Month Day Year <u>Feb 5 1958 19</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>June 18 1886</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cement Puller</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Md. Jennings Garrett Co</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Kemp Welch</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Glotfelty</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>215-10-6887</u>			
17. INFORMANT <u>Mrs Bertha Clark Smithsburg / Md R # 2</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Sigmoid</u> 153.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>2 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 36</u> 19 <u>58</u> , to <u>Feb 5</u> 19 <u>58</u> , that I last saw the deceased alive on <u>Feb 5</u> 19 <u>58</u> , and that death occurred at <u>730P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert Vh Campbell</u>				ADDRESS (Street, city or town, state) <u>M.D. 145 W Washington ST</u>		DATE SIGNED <u>2/6/58</u>	
PHYSICIAN'S NAME (Type) <u>Robert Vh Campbell</u>				<u>Hagerstown Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/8/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Goffman</u>				ADDRESS <u>Hagerstown Md</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 10 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Allen Smith</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

FEB 10 1958

RECEIVED

2508

Item 8 Film G226 3-6-58 et

CERTIFICATE OF DEATH

02514

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 64 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 217 James St				d. STREET ADDRESS 217 James St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Wilbur Middle Wilson Last Weller				4. DATE OF DEATH Month February Day 25 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 2, 1893		9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker		10b. KIND OF BUSINESS OR INDUSTRY Bakery		11. BIRTHPLACE (State or foreign country) Hagerstown Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Weller				14. MOTHER'S MAIDEN NAME Fannie Stem			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --- (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-09-9225		17. INFORMANT Address Mrs. Kittie M. Weller Hagerstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Arterio sclerosis INTERVAL BETWEEN ONSET AND DEATH 24 hrs. Years Years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio sclerotic heart disease							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan , 19 58 , to 25 Feb , 19 58 , that I last saw the deceased alive on 25 Feb , 19 58 , and that death occurred at 10:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Eldon G. Hoachlander M.D.				ADDRESS (Street, city or town, state) 115 W. Washington St. Hag. Md.			
DATE SIGNED							
PHYSICIAN'S NAME (Type) Eldon G. Hoachlander							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-1-58		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Scott F. Minnich & Son Hagerstown Md.				24a. REC'D BY REGISTRAR DATE MAR 3 '58		24b. REGISTRAR'S SIGNATURE Edgar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2530

CERTIFICATE OF DEATH

02515

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maugansville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Maugansville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 00 Rural Delvy.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last EDGAR JACOB WILHIDE		4. DATE OF DEATH Month Day Year Feb. 23 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 30, 1888
9. AGE (In years last birthday) 69 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dairy	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dairy		10b. KIND OF BUSINESS OR INDUSTRY Dairy	
11. BIRTHPLACE (State or foreign country) Frederick County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John D. Wilhide		14. MOTHER'S MAIDEN NAME Rosy Helen Fox	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-32-5624	
17. INFORMANT Mildred L. Fuss		Address 351 Central Ave. Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Arterio-sclerotic heart disease with DUE TO myocardial failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 5 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while at work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1952, to 23 Feb 58, 19, that I last saw the deceased alive on 22 Feb 1958, and that death occurred at 8:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE F F Lusby		DATE SIGNED 24 Feb 58	
PHYSICIAN'S NAME (Type) F F Lusby		ADDRESS (Street, city or town, state) 230 N Polomas Hagerstown Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/26/58	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc.		ADDRESS 1601 Penna. Ave. Hagerstown, Md.	
24a. REC'D BY REGISTRAR DATE FEB 28 1958		24b. REGISTRAR'S SIGNATURE O. H. Smith	

